

**THE KENTUCKY BOARD OF LICENSURE FOR NURSING HOME
ADMINISTRATORS
P.O. BOX 1360
FRANKFORT, KY 40602**

**APPLICATION FOR NURSING HOME ADMINSTRATORS
TEMPORARY PERMIT**

1. NAME: _____ 2. SSN _____ - _____ - _____

3. HOME ADDRESS: _____

CITY STATE ZIP

4. RESIDENCE PHONE: _____

5. FACILITY NAME: _____

6. FACILITY ADDRESS: _____

CITY STATE ZIP

7. BUSINESS PHONE: _____

8. ARE YOU A U.S. CITIZEN: ____YES ____NO 9. BIRTH DATE _____

10. HAVE YOU EVER APPLIED FOR OR BEEN DENIED A *NHA* LICENSE IN KY? ____YES ____NO
OR WITH ANY OTHER STATE? ____YES ____NO STATE(S) _____

11. HAVE YOU EVEN BEEN ISSUED A TEMPORARY PERMIT? ____YES ____NO

If yes, when _____ What facility? _____

12. DO YOU HOLD A VALID *NHA* LICENCE IN ANY STATE? ____YES ____NO

If yes, indicate license number _____ and State _____

13. HAVE YOU EVER HAD A LICENSE REVOKED, DENIED, OR SUSPENDED? ____YES ____NO

If yes, explain _____

14. HAVE YOU EVER BEEN CONVICTED OF A FELONY OR MISDEMEANOR? ____YES ____NO

If yes, please provide, date, nature of offense, and official report stating result of offense

15.

EDUCATION

COLLEGES/UNIVERSITIES	HOURS	MAJOR(S)	DEGREE(S)

16.

EMPLOYMENT HISTORY

BEGIN WITH YOUR PRESENT OR MOST RECENT JOB AND LIST FULLY AND ACCURATELY THE DETAILS OF EACH JOB YOU HAVE HELD DURING THE LAST THREE YEARS. ATTACH ADDITIONAL SHEET IF NECESSARY.

Employed: From: Mo.____ Yr.____ To: Mo.____ Yr.____ Describe Your Duties

Title or Position: _____

Name of Employer: _____

Address of Employer: _____

Employed: From: Mo.____ Yr.____ To: Mo.____ Yr.____ Describe Your Duties

Title or Position: _____

Name of Employer: _____

Address of Employer: _____

Employed: From: Mo.____ Yr.____ To: Mo.____ Yr.____ Describe Your Duties

Title or Position: _____

Name of Employer: _____

Address of Employer: _____

THE FOLLOWING IS REQUIRED BEFORE A TEMPORARY PERMIT CAN BE ISSUED.

*****A LETTER FROM THE FACILITY AT WHICH YOU WILL BE EMPLOYED, STATING THE REASON(S) FOR THE NEED OF THE TEMPORARY PERMIT.**

*****A CERTIFIED TRUE COPY OF THE OFFICIAL TRANSCRIPT MUST BE MAILED DIRECTLY TO THIS OFFICE FROM THE SCHOOL. A STUDENT COPY WILL NOT BE ACCEPTED.**

***** FIFTY DOLLARS IN A CHECK OR MONEY ORDER PAYABLE TO: THE KY. STATE TREASURER**

APPLICANTS AFFIDAVIT

I, THE APPLICANT NAMED IN THE ABOVE, DO HEREBY CERTIFY UNDER PENALTY OF LAW THAT THE INFORMATION CONTAINED HEREIN IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I AM AWARE THAT, SHOULD INVESTIGATION AT ANY TIME DISCLOSE ANY SUCH MISREPRESENTATION OR FALSIFICATION, MY APPLICATION COULD BE REJECTED OR MY LICENSE REVOKED BY THE KENTUCKY BOARD OF LICENSURE FOR NURSING HOME ADMINISTRATORS.

DATE_____ APPLICANT'S SIGNATURE_____

(Sign your name DO NOT PRINT)

LICENSE #_____ ISSUE DATE_____ EXPIRATION DATE_____